U.S. Department of Labor

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Issue Date: 13 April 2006

CASE NO.: 2005-BLA-05616

In the Matter of

MARRELL K. MARROW
Claimant

v.

DRUMMOND COMPANY, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances:

Patrick K. Nakamura, Esquire
For Claimant

Robin A. Adams, Esquire
For Employer

Before:

Janice K. Bullard
Administrative Law Judge

DECISION AND ORDER

This proceeding arises from a claim for benefits under the Federal Coal Mine Health and Safety Act of 1969, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in title 20 of the Code of Federal Regulations ("CFR"). Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

This decision is based upon consideration of the record and the arguments of the parties.[1]

I. ISSUES

(1) whether Claimant has pneumoconiosis;

(2) whether Claimant's pneumoconiosis arose out of coal mine employment;

(3) whether Claimant is totally disabled;

(4) whether Claimant's disability is due to pneumoconiosis; and

(5) whether there has been a change in any applicable element of entitlement upon which the order denying the previous claim became final.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Marrell K. Marrow, (hereinafter referred to as "Claimant") filed an initial claim for benefits under the Act on November 25, 1994, which was denied by the Director, Office of Workers' Compensation Programs for the U.S. Department of Labor ("the Director" hereinafter) on November 13, 1995. No further action on that claim was taken. DX 1.

On March 17, 2004, Claimant filed the instant (second) claim for compensation under the Act. DX 3. The Director named Drummond Company ("Employer" hereinafter) as the operator responsible for compensation of the claim. DX 14. On January 19, 2005, Director issued its determination that Claimant is not entitled to benefits under the Act. DX 18. Claimant disagreed with that determination and requested a formal hearing before the Office of Administrative Law Judges ("OALJ"). DX 19. The case was referred to the OALJ for a formal hearing, and was subsequently assigned to me.

I held a formal hearing in Birmingham, Alabama on October 25, 2005, at which time the parties had full opportunity to present evidence and argument. DX 1 through DX 24 were admitted into evidence. Admitted to the record were Employer's exhibit EX 1 and Claimant's Exhibit 1.[2] On December 7 and December 9, 2005, Employer and Claimant respectively filed briefs.

The regulations controlling the determination of a claim for benefits under title IV of the Act were amended in 2000, effective January 19, 2001. The revised regulations apply to all claims filed and all benefit payments made after January 19, 2001. 20 C.F.R. § 725.2(c) (2000).

[1] The following references appear throughout this Decision and Order: "DX" refers to Director's exhibits; "CX" refers to Claimant's exhibits, "EX" refers to Employer's exhibits and "Tr." refers to transcript of the October 25, 2005 hearing.

[2] Because the evidence is limited by regulation, this Decision and Order relies only upon that evidence that does not exceed the limitations.

As the instant claim was filed after the effective date of the revised regulations, the limitations on evidence set forth at 20 C.F.R. § 725.414 apply. Medical evidence that exceeds the limitations of § 725.414 "shall not be admitted into the hearing record in the absence of good cause." § 725.456(b)(1). The fact that the evidence is relevant does not alone constitute "good cause." The parties may not agree to the admission of excessive medical evidence. Smith v. Martin County Coal Corporation, BRB No. 04-0126 BLA (Oct. 27, 2004), (to be published at 23 BLR 1-). *See also* Phillips v. Westmoreland Coal Co., BRB No. 04-0379 BLA (Jan. 27, 2005, unpub.)

B. Factual Background

Claimant was born on January 19, 1933. DX 3. He was married to his wife E. Imogene Plyler Marrow, however, she has preceded him in death. DX 3. Claimant spent his working life in coal mining, and last worked as a miner in 1994. Id. His last employer was Drummond Company. Claimant worked 36 years in coal mining, and spent almost 26 years working for Drummond Co. DX 4, 6. He retired on September 23, 1994 when he couldn't do the work or climb the stairs as required. Tr. at 20-21, DX 3. Claimant's work as a cutting machine operator and shuttle car operator was performed underground. Claimant testified the last eight to ten years he worked as a bulldozer operator outside. Claimant testified that he took a cut in pay and came outside when the federal chest x-ray showed black lung and "they said they had to get me out of them mine . . ." Tr. at 17.

Claimant's other health problems include heart problems and previous open heart surgery six years ago. Claimant had lung surgery about a year ago. In addition, he was hospitalized recently for a gland infection. Tr. at 18-22. Claimant stated that his breathing prevents him from mowing the yard or doing the housework. Tr. at 18. He uses an inhaler as well as a nebulizer. Id. Claimant is a non-smoker. Tr. at 19.

C. Coal Mine Employment and Responsible Operator

The District Director determined that Claimant established 36 years of coal mine employment. Employer stipulated to 36 years of coal mine employment, to which Claimant also agreed. Tr. at 6. Accordingly, I find that Claimant has established 36 years of coal mine employment. The parties also agreed Claimant has no dependents for purposes of benefits augmentation. Id. Employer further conceded that it is the responsible operator. Id.

D. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Colliers, 512 U.S. 267 (1994).

In addition, this claim represents a subsequent claim, which requires analysis under the standard set forth by the Sixth Circuit Court of Appeals in Sharondale Corp. v. Ross, 42 F.3d 993 (6th Cir. 1994), adopted by the Fourth Circuit Court of Appeals in Lisa Lee Mines v. Director, OWCP, 86 F.3d 1358 (4th Cir. 1996)(en banc) rev'g 57 F.3d 402 (4th Cir. 1995), cert den. 117 S. Ct 763 (1997). That standard has been extended to claims adjudicated under the revised regulations. Dempsey v. Sewell Coal Co., 23 B.L.R. 1-53, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004) (*en banc*). In Dempsey, the Board held that where a miner files a claim for benefits more than one year after the final denial of a previous claim, the subsequent claim must also be denied unless one of the applicable conditions of entitlement has changed since the date of the denial. 20 C.F.R. § 725.309(d). The applicable conditions of entitlement are those upon which the prior denial was based. Id.

In order to determine whether a condition has changed, I must consider all of the new evidence, favorable and unfavorable, and determine whether the Claimant has proven at least one of the elements previously adjudicated against him. If the miner establishes the existence of an element, he has demonstrated a material change in condition. I would then need not require consideration of the evidence in the prior claim to determine whether it is qualitatively different from the new evidence, but rather consider whether all of the record evidence supports a finding of entitlement to benefits. Lisa Lee Mines, supra. at 1663 n. 11.

The Claimant's first application was denied because the evidence failed to establish that Claimant had pneumoconiosis that arose out of coal mine employment or that he was totally disabled by pneumoconiosis.

1. Presence of Pneumoconiosis

Section 718.201(a) defines pneumoconiosis as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis." Section 718.201(a)(1) and (2) defines clinical pneumoconiosis and legal pneumoconiosis. Section 718.201 (b) states:

> [A] disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202(a)(1) through (a)(4).

(1) x-ray evidence § 718.202(a)

(2) biopsy or autopsy evidence § 718.202(a) (2)

(3) regulatory presumptions § 718.202(a)(3)

a) § 718.304 - Irrebuttable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

b) § 718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

c) § 718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one of more coal mines prior to June 30, 1971.

(4) Physicians' opinion based upon objective medical evidence § 718.202(a)(4).

a. Chest X-Ray Evidence

Under § 718.202(a)(1), the existence of pneumoconiosis can be established by chest x-rays conducted and classified in accordance with § 718.102.[3] The current record contains chest x-ray evidence admitted as follows:

Date of X-ray	Date Read	Exhibit No.	Physician	Radiological Credentials	I.L.O. Classification
06/30/04	07/12/04	DX 9	Ballard	BCR	0/1 t, t
06/30/04	08/17/04	DX 9	Barrett	BCR; B	Quality reading only – quality 2
06/30/04	11/03/04	DX 11, 12	Scott	BCR; B	No pneumoconiosis
06/30/04	08/25/05	CX 1	Miller	BCR;B	1/1 p, q

It is well established that the interpretation of an x-ray by a B- reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 1-34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 1-537 (1983). The Benefits Review Board has also held that the interpretation of an x-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 1-131 (1984). In addition, a judge is not required to accord greater weight to the most recent x-ray evidence of record, but rather, the length of time between the x-ray studies and the qualifications of the interpreting physicians are

[3] A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51. A physician who is a Board certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001).

factors to be considered. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1998); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

The film taken on June 30, 2004 was interpreted as positive by Dr. Miller, who is board certified in Radiology and who is a B reader, and negative by Dr. Scott, who also is both a B-reader and board certified in radiology. Dr. Ballard, who is a Board certified radiologist found the x-ray showed some changes, but not in a sufficient profusion to diagnose pneumoconiosis. Dr. Barrett, who is also both a B-reader and board certified in radiology read the film for quality only.

Thus, the record includes both a positive and negative reading of the June 30, 2004 x-ray film by physicians with equal dual qualifications. Based on these equally credible readings by the highly qualified physicians which reach opposite results, I find that the x-ray evidence is evenly balanced. Under such circumstances, when the evidence is evenly balanced, the benefits claimant must lose since he bears the burden of persuasion. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 11 S.Ct. 2251 (1994). Based on the foregoing, I find that the x-ray evidence fails to establish the presence of pneumoconiosis.

b. Biopsy or Autopsy Evidence, § 718.202(a)(2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). Claimant had a lung surgery biopsy in March, 2004 and surgical pathology was performed on a section of the mass that was removed. On the pathological report, Dr. A. Ludwig stated the biopsy showed benign anthracosilicosis. On microscopic examination, Dr. Ludwig reported multiple old partially hyalinized granulomata with prominent deposition of anthracotic pigment. Dr. Ludwig reported further that examination under polarized light revealed the presence of silica particles. Dr. Ludwig's final pathological diagnosis was benign anthracosilicosis. DX 8.

Employer argues that the diagnosis of anthracosilicosis is not the same as pneumoconiosis. That argument, however, is contradicted by the specific language of the regulations. In Section 718.201, "pneumoconiosis" is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. The regulations states further, "This definition includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis. Clinical pneumoconiosis consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, *anthracosilicosis*, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment." (emphasis added) Since the definition specifically mentions anthracosilicosis, I find the pathological findings of anthracosilicosis on biopsy are sufficient to establish the presence of pneumoconiosis under the provisions of Section 718.202(a)(2).

c. Regulatory Presumptions, § 718.202(a)(3)

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305 and 718.306. Section 718.304 requires x-ray, biopsy or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

d. Physicians' Opinions, § 718.202(a)(4)

The fourth way to establish the existence of pneumoconiosis under § 718.202 is through physician opinions:

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

The record contains the following physicians' opinions.

G. Thomas, M.D. (DX 8)

Dr. Thomas stated in a letter dated April 21, 2004 he had been Claimant's treating physician on a referral for the evaluation of a lung mass. Dr. Thomas reported a thoracotomy and resection were performed on March 9, 2004. Dr. Thomas reported the mass, which had been increasing in size on chest x-ray, showed evidence of multiple, partially hyalinized granulomas with the presence of silica particles on pathological examination. He stated this finding was consistent with a significant exposure to coal dust. Dr. Thomas stated the presence of the mass is clearly due to coal mine dust exposure. He stated further that surgery was required because of the increasing size of the mass, the symptoms of shortness of breath and coughing and to rule out malignancy. Dr. Thomas concluded Claimant's significant coal dust exposure has resulted in coal miner's lung which has been proven by biopsy after the excision of the lung mass.

J. Hawkins, M.D. (DX 9,10)

Dr. Hawkins is certified in internal medicine and pulmonary disease. He examined the Claimant on June 20, 2004, and reviewed a job history of 36 years of mining, most of which was spent underground. The doctor noted Claimant's history of high blood pressure, diabetes mellitus and previous surgery in 2000 for coronary artery bypass graft and in 2004 for

thoracotomy. Claimant was a life-long non-smoker. Claimant's reported attacks of sputum, cough and wheezing were noted as was his dypsnea on exertion and resting. Claimant's height was noted as 67". Examination of Claimant's lungs showed a scar of previous surgery on inspection with symmetrical lungs, no tenderness on palpation and no dullness to percussion. On auscultation, Dr. Hawkins reported Claimant's lungs were clear. His blood pressure was 150/82, and other systems were within normal limits or showed no abnormality except for some illegible notes on the examination of his heart. Dr. Hawkins also performed pulmonary testing, including a chest x-ray which showed minimal parenchymal changes which were insufficient for the diagnosis of pneumoconiosis, pulmonary function study which showed no airflow obstruction and blood gas study which demonstrated adequate resting and exertion gas exchange. Dr. Hawkins diagnosed anthracosilicosis/pneumoconiosis based on the symptoms of dypsnea and based on the results of the lung biopsy. Dr. Hawkins concluded that Claimant had a mild to moderate respiratory impairment and he would be unable to do manual labor. In addition, Dr. Hawkins stated Claimant should avoid exposure to chemicals, dust and fumes. In an additional letter dated November 12, 2004, Dr. Hawkins, reiterated his findings in his examination report. He also stated Claimant's pneumoconiosis was contributing significantly to his disability. Dr. Hawkins noted Claimant's history of coronary artery disease and the fact Claimant is status-post coronary artery bypass graft surgery, but he stated that presumably there is adequate cardiac function currently.

A. Goldstein, M.D. (EX 1)

Dr. Goldstein, is certified in internal medicine, pulmonary disease and is a NIOSH B reader. Dr. Goldstein issued a report dated September 28, 2005 in which he stated that he had reviewed Claimant's claim file, including medical evidence and objective test results filed with this second claim for benefits. In a summary of his review, Dr. Goldstein observed that Claimant demonstrated no impairment and Dr. Goldstein questioned whether or not Claimant has pneumoconiosis. Dr. Goldstein noted the pathology did not diagnosis coal workers' pneumoconiosis, but did diagnose anthracosilicosis and some granulomas. Dr. Goldstein stated, "this patient has a diagnosis that was thought to be tuberculosis," and Dr. Goldstein speculated that some of the granulomas could be related to tuberculosis or whatever appeared to be tuberculosis. Dr. Goldstein also noted the normal results on exertional blood gas study and, thus, he stated Dr. Hawkins finding that Claimant is disabled is not supported by his own data. Dr. Goldstein also stated the restrictive defect could be accounted for by Claimant's weight gain and the fact of the previous bypass surgery. Dr. Goldstein stated if the mass lesion was secondary to coal workers' pneumoconiosis, then the previous chest x-ray readings would be distinctly abnormal and the pulmonary function study would have shown restriction and some obstruction. However, he noted no opacities of coal workers' pneumoconiosis or silicosis were seen on chest x-ray. Dr. Goldstein concluded Claimant does not have pneumoconiosis, and even if pneumoconiosis is present, Claimant does not have any impairment due to pneumoconiosis. Dr. Goldstein also noted that although Dr. Hawkins presumed Claimant's cardiac status to be normal, that has not been objectively evaluated.

Discussion

A medical opinion is well-documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion that is based on a physical examination, symptoms and a patient's work and social histories may be found to be adequately documented. Hoffman v. B & G Construction Co., 8 B.L.R. 1-65 (1985). A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields, *supra.* A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989).

Following his review of Claimant's medical records, Dr. Goldstein concluded that Claimant did not have pneumoconiosis. Dr. Goldstein relied in large part on his statement that the biopsy did not diagnose coal workers' pneumoconiosis but diagnosed anthracosilicosis. As noted above, however, anthracosilicosis is specifically included in the regulatory definition of pneumoconiosis. Therefore, I accord little weigh to Dr. Goldstein's conclusion regarding the presence of pneumoconiosis. I also find Dr. Goldstein's statement that if the lung mass were due to pneumoconiosis, the chest x–ray readings would be obviously abnormal is not sufficient to outweigh the pathological finding of pneumoconiosis. I accord greater weight to the opinion of the physician who actually examined Claimant's lung tissue as opposed to Dr. Goldstein's findings on review of the medical evidence. Furthermore, I note the record does include positive chest x-ray readings which Dr. Goldstein apparently did not credit. The record does not include the x-ray films which were the basis for the recommendation for the lung surgery, however, I find Dr. Thomas' opinion as the miner's treating physician for his surgery credible and conclude he accurately summarized the findings on the x-ray films which pre-dated Claimant's lung surgery. Thus the record establishes x-ray films which were sufficiently abnormal that the Claimant's treating physicians recommended lung surgery. Thus, there is little basis for Dr. Goldstein's statement that the changes could not be pneumoconiosis since the x-ray evidence was not obviously abnormal and, therefore, I accord little weight to this conclusion.

Dr. Hawkins diagnosed pneumoconiosis based specifically on the biopsy findings. In addition, Dr. Thomas also concluded the mass present on chest x-ray and for which Claimant has lung surgery was related to Claimant's coal mine dust exposure. These opinions are both well supported by the actual pathological report. Thus, I find these opinions are both well-reasoned and well supported.

Considering the physician opinion evidence as a whole, I find that it demonstrates that Claimant has pneumoconiosis. As noted above, I accord less weight to Dr. Goldstein's finding that pneumoconiosis was not present since he relied upon a narrow definition of pneumoconiosis in concluding that the biopsy report did not establish the presence of pneumoconiosis. I accord greater weight to the contrary opinions of Drs. Thomas and Hawkins which are consistent with the regulatory definition and which conclude Claimant does have pneumoconiosis.

e. Other Evidence

Records of a miner's hospitalization or medical treatment for a respiratory or pulmonary or related disease may be received into evidence. § 725.414(a)(4). The record, however, does not include the hospital report from the miner's recent lung surgery nor does it include any medical treatment notes.

f. Totality of Evidence

Considering all of the evidence together, I find that it establishes that Claimant has pneumoconiosis. The medical opinion evidence that Claimant has pneumoconiosis, specifically the persuasive medical opinion reports of Drs. Thomas and Hawkins, are supported by objective results of the surgical biopsy. I find the biopsy evidence which included an actual examination of Claimant's lung tissue more persuasive than the chest x-ray evidence which was equally balanced. I find that the positive biopsy lends support to the medical opinions of Drs. Thomas and Hawkins and together find this evidence outweighs the contrary medical opinion review report of Dr. Goldstein. Thus, by the preponderant evidence I find that Claimant has met his burden of proof on this issue.

2. Pneumoconiosis arising out of coal mine employment

Based upon Claimant's coal mine employment history of at least 36 years, he is entitled to a rebuttable presumption that pneumoconiosis arose out of his coal mine employment. § 718.203(b). No evidence has been presented to rebut the presumption, and accordingly, I find that Claimant's pneumoconiosis arose out of coal mine employment.

3. Total disability

In order for Claimant to prevail, he must establish that he is totally disabled due to a respiratory or pulmonary condition. Total disability is defined in § 718.204(b)(1) as follows:

> A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone prevents or prevented the miner (i) [f]rom performing his or her usual coal mine work; and (ii) [f]rom engaging in [other] gainful employment in a mine or mines.

§ 718.204(b)(1). Non-pulmonary and non-respiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. § 718.204(a). Additionally, § 718.204(a) provides that:

> If, however, a non-pulmonary or non-respiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition shall be considered in determining whether the miner is or was totally disabled [under the Act].

Claimant may establish total disability in one of four ways: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right-sided congestive heart failure; or reasoned medical opinion. 20 C.F.R. section 718.204(c)(1)-(4).

a. Pulmonary function test evidence

In order to establish total disability through pulmonary function tests, the FEV_1 must be equal to or less than the values listed in Table B1 of Appendix B to this part and, in addition, the tests must also reveal either: (1) values equal to or less than those listed in Table B3 for the FVC test, or (2) values equal to or less than those listed in Table B5 for the MVV test or, (3) a percentage of 55 or less when the results of the FEV_1 test are divided by the results of the FVC tests. 20 C.F.R. section 718.204(c)(1)(i)-(iii).

In addition, the assessment of pulmonary function study results are dependent on Claimant's height. Protopappas v. Director, 6 B.L.R. 1-221 (1983). Claimant's height was recorded as 67", which I used in evaluating the study.

The results of the newly submitted pulmonary function study is as follows:

DATE	EX. NO.	PHYSICIAN	AGE HT.	FEV_1	FVC	EFFORT	QUALIFIES
06/30/04	DX 9	Hawkins	71 67"	1.86	2.39	good	No

The results of the one newly submitted pulmonary function study does not meet the qualifying values set forth in Appendix B for FEV1. I find, therefore, that the pulmonary function test results are non-qualifying under the regulations. Accordingly, Claimant has not demonstrated total disability by pulmonary function study evidence.

b. Arterial blood gas evidence

The results from the one newly submitted arterial blood gas study are as follows:

DATE	EX. NO.	PHYSICIAN	pCO_2	pO_2	QUALIFIES
06/30/04	DX 9	Hawkins	38 34*	79 84*	No

* after exercise study

The studies did not produce qualifying values, either at rest or after exercise. Accordingly Claimant has not established total disability by arterial blood gas study evidence.

c. Cor pulmonale

Under section 718.204(b)(2)(iii), total disability can be established where the miner has pneumoconiosis and the medical evidence shows that he suffers from cor pulmonale with right-

sided congestive heart failure. There is no current record evidence of cor pulmonale with right-sided congestive heart failure. Therefore, Claimant has failed to establish total disability under 20 C.F.R. section 718.204(b)(2)(iii).

d. Medical opinion evidence

Total disability may also be established by the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. 20 C.F.R. section 718.204(b)(3)(iv).

Dr. Hawkins concluded Claimant's pneumoconiosis had caused a mild to moderate respiratory impairment and Claimant could not do manual labor. Dr. Hawkins also concluded Claimant should avoid further exposure to chemical, dust and fumes. In contrast, Dr. Goldstein, relying upon the objective laboratory results which were non-qualifying, concluded Claimant was not disabled by pneumoconiosis, if pneumoconiosis was present. Since Dr. Goldstein's report is better supported by the actual results on the newly submitted pulmonary tests, I find his report outweighs the contrary conclusions of Dr. Hawkins. Thus, I find Claimant has not established total disability under 20 C.F.R. § 718.204(b)(2)(iv).

Considering all the medical evidence together including the non-qualifying pulmonary function study and blood gas study of taken by Dr. Goldstein in 1995 (DX 1) and Dr. Goldstein's medical opinion upon examination in 1995 that Claimant did not have any pulmonary or respiratory impairment (DX 1), as well as the more recent non-qualifying pulmonary test results and Dr. Goldstein's better supported medical review opinion, I find that Claimant has not established that he is totally disabled since his pulmonary function study results are non-qualifying, the blood gas study results are non-qualifying and the better supported medical opinion evidence concludes he is not disabled by pneumoconiosis.

4. Total disability due to pneumoconiosis

Claimant bears the burden of proving that pneumoconiosis is a substantial contributor to his total respiratory disability. § 718.204(c)(1). Sections 718.204(c)(1)(i) and (ii) provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

§ 718.204(c)(1)(i), (ii). Disability due to pneumoconiosis may be established by a documented and reasoned medical report. § 718.204(c)(2). Since the evidence does not establish that Claimant is totally disabled, however, it also fails to establish total disability due to pneumoconiosis.

III. CONCLUSION

Based on my review of the evidence, I find that Claimant has established one of the applicable conditions of entitlement since the denial of his previous claim since the evidence now clearly establishes the presence of pneumoconiosis which arose from his coal mine employment. Therefore, this claim shall not be denied on the basis of the prior denial. Since I find upon consideration of all the evidence of record, however, that Claimant has failed to establish that he is disabled due to pneumoconiosis, however, I find Claimant is not entitled to benefits under the Act.

ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which the Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this claim, the Act prohibits the charging of any fee to Claimant for representation services rendered in pursuit of his claim.

ORDER

The claim of MARRELL K. MARROW for benefits under the Act is hereby DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).